GetA*FluShot*.com

A Professional Health Care LLC Company, Established 1989
Community Immunization Provider since 1991

City of Seattle Consent & Claim Form: Influenza Immunization

Check primary insurance plan: ☐ **Group Health** ☐ **Aetna Preventive** ☐ **Aetna Traditional (Local 77 only)**
Aetna SPOG and Most Traditional plans not accepted for vaccinations ☐ Medicare Part B ☐ _____

For use by City of Seattle and King County employees only

Last Name: First Name: (middle initial) MI:

Primary Insurance ID #

(Secondary Insurance)
Insurance Plan: ID Number:

(Month/Day/Year)

Date of Birth: _____ Sex: ☐F ☐M

Mailing Address:

City: State: **WA** ZIP Code:

Phone #: (_____)_____-_____

Have you ever had a flu vaccination before? ☐Yes ☐No ☐Unsure Are you allergic to eggs? ☐Yes ☐No

Have you ever had a severe reaction to a flu shot? ☐Yes ☐No Are you allergic to latex? ☐Yes ☐No

Do you have a history of Guillain-Barre Syndrome? ☐Yes ☐No If female, are you pregnant? ☐Yes ☐No

I have read/had explained to me the Vaccine Information Statement about influenza and influenza vaccine. I have had a chance to ask questions and had them answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I agree that neither GetAFluShot.com nor its sponsor or host site shall have any responsibility or liability if I contract influenza or other respiratory diseases, or suffer any other adverse reaction, following administration of the flu shot. I understand that I am responsible for payment for the vaccine if my insurance carrier denies payment.

X Signature of responsible person: _____ Relationship: _____ Date: _____

Community Provider/Health Plan Use Only

Federal Tax ID: 91-1754065 Service Location: 60
Practice NPI # 1528244282
Rendering Provider NPI# 1558496158
CPT Code (Inj. vaccine): 90658 CPT Code (admin): 90471

Diagnosis Code: V04.81

Clinic Use Only

Clinic Location: _____

Date of Vaccination: _____

Mfg/Lot #: _____ Expiration Date: _____

Nurse's Initials: _____ Site of Injection: **L R Deltoid**

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